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ABSTRACT

Children who lack health insurance do not have access to preventive care, placing them at greater risk of serious illness. This special report of the Voices for Illinois Children describes federal and state efforts to address the problem of uninsured children and issues that will need to be monitored as Illinois begins to help children access health care. The report describes the development of the Children's Health Insurance Plan (CHIP) and states' requirements for participation in the plan. In addition, the report describes Illinois' two-phase approach to helping children access health care: (1) Medicaid expansion; and (2) KidCare, including eligibility, covered services, affordability, accessibility, continuous eligibility, program for insured children, and program evaluation. Characteristics of current state CHIP policies and plans are described regarding eligibility, program structure, services covered, cost-sharing, and outreach and enrollment. The report maintains that the key issues to be monitored regarding KidCare deal with parents' knowledge about the program, its affordability, and children's receipt of services. The report concludes with a table summarizing the provisions of KidCare's program for uninsured and insured children. (KB)



Special Report

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Closing the Gap: Insuring Children in Illinois

In 1997, Voices for Illinois Children chronicled the conditions of the state's 300,000 uninsured children in the report, *Falling Through the Gap: Uninsured Children in Illinois*. Nearly 1 in every 10 children in Illinois are uninsured, either because they are not participating in Medicaid or in an employer-sponsored health insurance program. Of uninsured children in Illinois:

- ❖ 67 percent are from families whose income exceeds the federal poverty level;
- ❖ 59 percent live in two parent families;
- ❖ 56 percent live in suburban or rural areas.

Children who lack health insurance do not have access to preventive care – placing them at greater risk of serious illness. Children without

insurance are twice as likely to be hospitalized for immunizable conditions and one-and-a-half times as likely to be hospitalized for asthma.¹ Further, children without health insurance are less likely to get care for injuries, see a physician when chronically ill or get necessary dental care.² By providing children with access to regular preventive care, we can decrease the risk of serious illnesses and provide them with the opportunity to develop into healthy adults.

In this *Special Report* we describe federal and state efforts to address the problem of uninsured children and issues that will need to be monitored as Illinois begins to help children access health care.

The Opportunity

On August 5, 1997, President Clinton signed into law the Balanced Budget Act of 1997 which provided states with a unique opportunity to address the problem of uninsured children. The Children's Health Insurance Plan (CHIP) is the most significant new investment in children's health since the original enactment of Medicaid in 1965 and sets aside \$24 billion over 5 years to provide health insurance for many of the nation's 10 million uninsured children.³

These federal funds can be used to help children with family incomes too high for Medicaid but below 200% of poverty (\$26,660 a year for a family of three.) Some states, including those that offered expanded Medicaid coverage before the new federal law passed, will be able to help additional children with slightly higher family incomes. The funds will be distributed in the form of reimbursements to states and will allow states to determine the form of health care coverage. In particular, each state can use its funds to expand Medicaid, create a new state

program to cover children's health insurance or combine these approaches. Regardless of which plan is chosen, states must:

- provide a fairly comprehensive set of services that meets a "benchmark" minimum established by certain commercial insurance plans, i.e., a state employee health plan or the largest HMO plan in the state;
- ensure that any new plan will charge no more than 5% of family income; and spend at least 90% of its funds on insurance coverage and no more than 10% on administration, outreach and direct health services;
- maintain the current Medicaid eligibility for children that was in effect as of June 1997.

States participating in CHIP are provided with a reimbursement from the federal government. In 1998, Illinois can draw on as much as \$128.8 million through reimbursement for services. For every \$1 Illinois spends on this program, we will be reimbursed \$0.65.

In order to become eligible, each state must submit a plan for approval to the U.S. Health Care Financing Administration (HCFA).

This new federal program provides significant federal funding while giving states flexibility to address the needs of uninsured children. States now face an important set of decisions about how best to meet the needs of uninsured children.

The Illinois Decision

Prior to CHIP legislation, Illinois was one of only three states that had not taken formal steps to establish some type of children's health insurance beyond the minimum federal requirements of Medicaid. Illinois now has a tremendous opportunity to reach out to uninsured children and provide them with health care coverage. The challenge, however, is to create a plan that covers as many children as possible with comprehensive, affordable, and accessible health insurance.

Illinois chose a two-phase approach to helping children access health care.

Phase I: Medicaid Expansion

In January, 1998, Governor Edgar expanded Medicaid making eligible all children under age 19 with a family income of 133% of the federal poverty level and pregnant women and children up to 200% of poverty.

This expansion will provide health insurance to more than 40,000 children and approximately 2,900 pregnant women who formerly had been uninsured.

In addition to this immediate expansion, the Governor created a Task Force composed of legislators, health care providers, state administration officials, and child health care advocates to craft a program that provides coverage to more uninsured children.

Phase II: KidCare

After many weeks of deliberation among Task Force members and the broader child health community, on May 6, 1998, the Governor and legislative leaders unveiled the children's health insurance plan – known as KidCare – which moves Illinois a long way toward providing health care benefits to many of the state's uninsured children. The plan covers a broad range of children and contains several key components.

Eligibility: Children under age 19 whose family income is less than 185% of poverty and who are not currently enrolled in a health insurance plan are eligible.⁴

1998 Income Eligibility for KidCare⁵

Family Size ¹	Income at 185% of Poverty ²
2	\$20,073
3	\$25,253
4	\$30,433
5	\$35,613

Notes: 1) Family includes adults and children. A family size of 3 could be a family with two parents and a child or a single parent with two children. 2) Poverty thresholds change yearly.

Therefore, a working parent with two children who earns \$24,000 a year would be able to enroll his or her children in KidCare as long as the children are not currently enrolled in another health insurance program.

This program is not an entitlement. Children may enroll as long as state and federal funds are available.

Covered Services: KidCare covers a broad range of prevention, intervention, emergency and acute care services for children, including:

- Well baby visits
- Immunizations
- Inpatient and outpatient hospital services
- Medical/health screenings
- Dental care
- Annual hearing and vision screenings
- Urgent care
- Inpatient, outpatient, and emergency mental health and substance abuse services
- Rehabilitative and habilitative services
- Prescription drugs

In essence, Illinois will provide children enrolled in KidCare access to the same services offered in the Medicaid program.

Affordability: KidCare requires that parents share in the cost of this health care through premiums and co-payments.

- for families with **income under 150% of poverty** there is a co-payment of \$2 per visit. There is a \$100 annual family cap on co-payments.⁶ This means that parents will

have to pay no more than \$100 per year, per family in co-payments.

- for families with **income between 150% and 185% of poverty**, there is a monthly premium of \$15 for one child, \$25 for two children and \$30 for three or more children. There is also a co-payment of \$5 per visit and a \$100 annual family cap on co-pays.

Co-payments cannot be charged for well-child and other regular prevention services.

Accessibility: Children who are enrolled in the program will be able to continue to utilize community-based health care professionals or chose to join an HMO as long as they are part of the Medicaid provider network.

Outreach will be critical for ensuring that children enroll and receive needed health care services. As part of KidCare, state administrators will be working to increase outreach efforts including working with schools and other community organizations to reach out to parents and to shorten the enrollment process.

Continuous Eligibility: This new program enables children to retain health care coverage for an entire year regardless of how a parent's income or employment status changes.

Program for Insured Children: KidCare also provides assistance to low-income children already covered by health insurance. This plan will offer a subsidy to families with incomes under 185% of poverty whose children have health insurance through an employer or a private insurance company. This subsidy is designed to help offset the cost of premiums.

The amount of subsidy available to a family will be about \$65 per child per month.⁷ Subsidy will only be available to offset the cost of premiums. For example, if a family pays \$50 per month for health care for two children through an employer-

based plan, that family will only be eligible to receive a benefit of \$50 per month.

Program Evaluation: KidCare will be assessed at 6 months and 12 months to ensure that Illinois

is on the right track and to help policy makers learn more about enrollment procedures, premiums, co-payments and other factors that will impact program participation.

Other State Children's Health Insurance Plans

As of April 30, 1998, 41 states had submitted state child health plans to the federal government for approval or had passed CHIP legislation.⁸ Of these, nine – including Illinois for Phase I – have already received federal approval and are moving to implement their CHIP programs. Two states, Washington and Wyoming, have decided not to take action on CHIP in 1998.

While some states are still struggling to determine how they will address this important issue, many have committed to policies that will greatly benefit children. In a recent report, the Children's Defense Fund compared current state CHIP policies and plans and highlighted the following:⁹

Eligibility: Most states are acting boldly to help uninsured children access health care. Of 40 states proposing income eligibility standards:

- 20 states will cover children up to or above 200% of the federal poverty level (about \$27,300 for a family of three.)
- 3 states – Connecticut, Missouri and Vermont – are covering children up to 300% of poverty.
- 11 states have set eligibility at or below 150% of poverty.

Program Structure: Of the 38 states that have made decisions about basic program structure, 25 have proposed to either expand Medicaid or develop a program that is similar to Medicaid but is not an entitlement.

Services Covered in Benefit Package: Most states are basing covered benefits on children's unique health needs. Among the 38 states that

have made a decision about covered benefits, 25 use the Medicaid benefit package which was developed with children in mind.

Some states have chosen to omit basic categories of services. For example, Colorado will not cover dental care services in its benefit package.

Cost-Sharing: While some states are utilizing significant cost-sharing, the majority do not impose premiums and co-payments for the poorest children eligible for CHIP – families with incomes below 150% of poverty.

- 13 states utilize no co-pays for families with income below 185% of poverty.
- 9 states charge \$200 or more a year in premiums to low-income working families with two children eligible for CHIP.
- 10 states require families to begin paying co-pays for children at 100% of the federal poverty level.

Outreach and Enrollment: As part of the federal requirements, states must describe how they are going to publicize this new program and streamline enrollment. Of the 41 states that have developed plans:

- Most are working on shortening the application form and simplifying enrollment processes;
- Almost all plan to develop a special media campaign;
- Several states, including California and Massachusetts, will contract with community-based organizations to help find and enroll hard-to-reach children

Insuring Illinois Children: Monitoring Progress

With the development of KidCare, Illinois has taken a significant step forward in ensuring that more children have access to health care. As Illinois begins to implement the new children's health insurance plan, monitoring will be necessary to determine if we have met the goal of improving the health of low-income children. In particular, the following key issues must be monitored:

Do parents know about KidCare? Are outreach efforts effective in reaching families? What is the best way to let parents know this program exists? If families are not aware of KidCare, what kinds of adjustments are needed to improve outreach and enrollment.

Is KidCare affordable? Are the premiums and co-payments set at a level that encourages rather than discourages enrollment? If enrollment is low, in what ways does our cost sharing structure need to be changed?

Are children receiving services? Are children who are enrolled able to access care in their communities; i.e. are medical facilities and staff available to treat children? What kinds of changes need to be made to ensure that children have access to services and providers?

To get more information on how to enroll in KidCare call 1-800-252-8635.

This *Special Report* was co-authored by Ami Nagle and Andrea Havill. For more information about this topic and other state fiscal issues please call Voices for Illinois Children at (312) 456-0600.

Voices is a non-profit, non-partisan, citizen-based advocacy group addressing problems faced by Illinois children and their families. Through research, public education and coalition-building, Voices generates support from civic, business and community leaders for cost-effective and practical proposals to improve the lives of Illinois children. Voices' President is Jerome Stermer and Chair of the Board is Kathleen Halloran of NICOR.

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Endnotes

1. Ami Nagle and Sarah Adkins. *Falling Through the Gap: Uninsured Children in Illinois*. Voices for Illinois Children. 1997.
2. United States General Accounting Office, Health, Education and Human Services Division. *Health Insurance for Children: Private Insurance Coverage Continues to Deteriorate* #96-129. 1996.
3. Brian Bruen and Frank Ullman. *Children's Health Insurance Program: Where States Are, Where They Are Headed*. Urban Institute. Series A, No. A-20. May 1998.
4. Non-citizen children are only eligible to enroll under certain circumstances.
5. This table provides basic income guidelines. Exact income eligibility will be set as part of the rules process. Children in families with higher incomes may be eligible for the program.
6. This \$100 family cap does not include the cost of premiums.
7. The amount of the subsidy will be set on a year-to-year basis.
8. Some states have submitted temporary plans to HCFA and will submit full plans later this year.
9. Children's Defense Fund. *CHIP Check-up: A Healthy Start for America's Children*. May, 1998.

Overview of Illinois Children's Health Legislation – KidCare

Program for Uninsured Children	
Eligibility	Includes children under age 19 with a family income less than or equal to 185% of poverty -- or \$25,253 for a family of three. To be eligible children must not currently be enrolled in a health insurance program.
Benefits	Covers a broad range of prevention, intervention, emergency and acute care services for children, including: <ul style="list-style-type: none"> • Well baby visits • Immunizations • Inpatient and outpatient hospital services • Medical/health screenings • Dental care • Annual hearing and vision screenings • Urgent care • Inpatient, outpatient, and emergency mental health and substance abuse services • Rehabilitative and habilitative services • Prescription drugs
Cost-Sharing	Requires that parents share in the cost of health care through premiums and co-payments. <ul style="list-style-type: none"> • for families with income under 150% of poverty there is a co-payment of \$2 per visit. There is a \$100 annual family cap on co-payments. This means that parents will have to pay no more than \$100 per year, per family in co-payments. • for families with income between 150% and 185% of poverty, there is a monthly premium of \$15 for one child, \$25 for two children and \$30 for three or more children. There is also a co-payment of \$5 per visit and a \$100 annual family cap on co-payments.
Funding	\$51.6 million in FY99 – \$18.0 million from state and local funds.
Administration	Department of Public Aid
Program for Children with Private Health Insurance	
Eligibility	Includes children under age 19 with a family income of less than or equal to 185% of poverty – or \$25,253 for a family of three. To be eligible, children must be enrolled in a health insurance program – either private or employer-based.
Subsidy Amount	Exact amount will be determined annually. The amount of subsidy available to a family will be about \$65 per child per month. Subsidy will only be available to offset the amount of premiums that a parent pays.
Funding	\$18 million in General Revenue Funds in FY99.
Administration	Department of Public Aid



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